PLEASE DO NOT STAPLE IN THIS AREA

Sample Claim for Health Dept. Providers
Interperiodic Health Check Screening

APPROVED OMB-0938 0008

HEALTH INSURANCE CLAIM FORM

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
(Medicare #) [X] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
900000000M

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Robin, Christopher

3. PATIENT'S BIRTH DATE MM DD YY: 04 20 1989 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
23 Winnie The Pooh Lane

6. PATIENT RELATIONSHIP TO INSURED
Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Riddle
STATE: NC

8. PATIENT STATUS
Single [ ] Married [ ] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY
STATE

ZIP CODE: 22332
TELEPHONE (Include Area Code): (919) 222-3333

ZIP CODE
TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State) [ ] YES [ ] NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V20.2
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03	27	2000	03	27	2000	11	01	W8016	1N		77.75	1				
2																
3																
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.
3311

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ 77.75

29. AMOUNT PAID $

30. BALANCE DUE $ 77.75

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED Signature on file DATE 4/2/00

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

16

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Pooh County Health Dept.
123 Eeyore Lane
Riddle, NC 23456

PIN# 8922111 GRP# 3404000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500